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Correspondence

Ian Ramsey and the practice of medicine

SIR

It is with considerable reluctance that one ventures to disagree with so distinguished an historian and theologian as Professor G R Dunstan. However, in the course of the clear and persuasive picture which he presented of Ian Ramsey last year and which was reprinted in your December issue, (pages 189-94) there are at least two points which I would like to make – though I have been warned that your journal is unlikely to print them!

First, while I welcome Professor Dunstan's recognition of the fact that the Abortion Act 1967 has led to 'abortion virtually upon demand', I question his interpretation of the Bourne judgement. If his sentence on page 192 beginning 'Termination was a criminal procedure' means anything, it must surely mean that the Bourne case established the principle that abortion was lawful if it were necessary to save the life of the mother. But that was not the point of the Bourne judgement, as anyone who cares to look up the case will find. It concerned Bourne's decision to terminate the pregnancy of a girl of under 15 who had been raped, and whose life, as Bourne admitted in cross-examination, was not in 'immediate' danger. Bourne's argument was that it was the girl's 'nervous sytem' which would 'probably be adversely affected': and the judge in his summing up echoed these words:

'I think myself that . . . if the doctor is of opinion on reasonable grounds, on adequate knowledge, that the probable consequences of the continuance of the pregnancy would . . . make the woman a physical wreck or a mental wreck, then he operates, in that honest belief, "for the purpose only of preserving the life of the mother".' *British Medical Journal* 1938; 2, Jul 23: 204.

The second point on which I take issue with Professor Dunstan is on the question of the so-called 'pre-embryo', (pages 190-191). Professor Dunstan informs us that 'Today's embryologists' (no names are specified) 'are telling us that the formation of the zygote initiates a pre-embryonic stage of cellular fluidity and totipotency out of which an *individual* human being' (his italics) 'may begin to shape at about the fifteenth day – or it may not'. The argument that the genetic constitution of the zygote is uniquely different and will remain uniquely different and individual throughout the life of that human being if it is allowed to develop normally is not met. Professor Dunstan must surely know that the expressions 'cellular fluidity and totipotency' to which he refers denote the fact that the single cell which is the zygote contains within itself the capacity to divide and thus form all the cells of the adult human body, however specialised. It does not denote the fact that the cell can divide and develop into something which is not human, unless of course it is grossly abnormal. The individuality is present from the very beginning in the overwhelming majority of cases, and policy must take account of that fact.

G CHOWDHARAY-BEST MA
27 Walpole Street,
London SW3 4QS

Care of the severely handicapped

SIR

Simon Neale denies that under present conditions 'there is insufficient to provide basic care for all'. Two comments on this: 1) What we are talking about with the care of the severely handicapped is not 'basic' care but total care, 24 hours a day, for a lifetime. Who is going to undertake it if the mother cannot be dragooned into it by being made to feel guilty? 2) As children and adults are now dying daily who could be restored to good health with early treatment for which resources are not currently available, does he not think certain priorities in health care ought to be established based on the likely subsequent quality of life? If not, is he contemplating cuts elsewhere, in housing, education, defence or where? Or is he contemplating substantial increases in taxation? Or does he believe there is a bottomless pit of resources? It is no longer sensible to discuss these issues in a financial vacuum. If he was contemplating cutting defence expenditure in order to increase expenditure on preventive medicine, including improving our lamentable abortion services, then I might well agree with him.

I did not argue that mothers should be persuaded to have abortions rather than handicapped babies (this is hardly necessary as several national surveys have demonstrated), despite the fact that in my view, the quality of their lives and their children's lives is likely to be very poor. I do argue that women should be given a genuine choice, since if they decide to continue with such a pregnancy the burden on them in the future will be very heavy, and the chances of their marriages breaking up in consequence may be up to nine times the normal rate (1). The real difference between Mr Neale and myself is that I am very bothered about the quality of life of the carers, while I am not very concerned about fetuses. Mr Neale's concern is the reverse of mine. These are matters of individual judgement, and cannot be 'proved' either way, which is why the abortion debate is still with us.

Reference

(1) Tew B J, Laurence K M, Payne H, Rawnsley K. Marital stability following the birth of a child with spina bifida. *British Journal of Psychiatry* 1977; 131: 79-82.

MADELEINE SIMMS
17 Dunstan Road, London NW11 8AG

Reply to Simms

SIR

The two questions Madeleine Simms asks have got simple answers which I will be pleased to provide. Less happily, they also show that she has missed the point of my earlier correspondence, so a final reiteration of basic positions also seems necessary.

But facts first.

1) Who is to provide care for handicapped children if their parents cannot be 'dragooned' into it? Or even coerced, conscripted, blackmailed, or bludgeoned into it? The answer is the care and nursing staff of local authorities, the National Health Service (NHS), and the voluntary sector, along with foster parents and volunteers.

2) On the question of the raising and deployment of revenue: yes, I am advocating cuts in defence expenditure; yes also to increased taxation were it to be necessary and also not regressive; no to prioritising health care according to subjective and unverifiable criteria such as – 'quality of life'. Of what does this concept consist, how is it to be measured and operationalised, and what is its logical relationship to other concepts such as handicap and rights to life?

Now back to issues again. Ms Simms consistently attempts to justify the killing of handicapped children (which under present British law would be infanticide or murder) by portraying it as the lesser of two evils. Either we kill someone, or worse things happen, such as mothers being dragooned into drudgery, divorce, etc. . .

I have not, as Ms Simms appears to think, argued that she has merely applied incorrect moral weighting to the horns of this dilemma. What I have done is to consistently argue that this is a false dilemma, and that neither of these immoral alternatives is necessary. Not killing, nor yet dragooning etc. . . It is therefore disconcerting to be labelled as one who is not very bothered about the quality of life of the carers, when an understanding of my position would surely preclude this. Perhaps Ms Simms thinks that the ethics of debate are, like the ethics of killing, 'matters of individual judgement'.

SIMON NEALE
7 Bryanston Street, Blandford Forum, Dorset

Editor's note

The editor feels that these two letters should end this particular correspondence.

The Patient Advocate as Adversary

SIR

The relationship between physician and patient realises unequal information and skill between them; by agreement the physician is to use his skill on the patient's behalf. The physician must foremost maintain the role of patient advocate; physicians are to guide the public, and not become agents of the state or any other employer (1).

However, medicine is becoming a business tuned to the government, hospitals and other employers. The danger lies in the loss of control – for the physician as advocate and the patient as an agent of free choice. One path is the development of the physician-employee, with loss of self-determination and ability to respond for the patient (2).

In America the Public Health Service has produced outstanding results in health care; other public sectors employing physicians however, have allowed just this loss both of self-determination and ability to respond for the patient to occur. This has been through the aggrandisement of a non-medical administrative cadre who both act as patient advocates and are appointed as such. With scant medical knowledge, an adversarial role can be taken towards the physician. While this situation is not the norm, it is a trend.

The international nursing code supports the view of those nurses who perceive themselves as that of patient advocate (3). In the conflict generated by administrative versus professional roles for advocacy, one solution may be that the physician and nurse advocate together for their patients.

References

(1) Abrams F R. Patient advocate or secret agent? *Journal of the American Medical Association* 1986; 256, 13: 1784–1785.

(2) May W E. On ethics and advocacy. *Journal of the American, Medical Association* 256, 13: 1786–1787.

(3) Beauchamp T L, Childress J F. *Principles of biomedical ethics* (2nd ed). New York: 1983: 249, 332.

JOHN HENRY McWHORTER, MD,
PO Box 201, McWhorter, WV 26401 USA